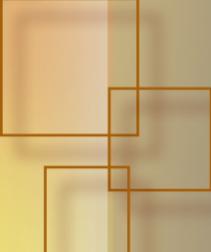
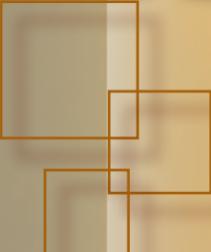


**Arizona Health Care Cost Containment System
Arizona Department of Health Services
Children's Rehabilitative Services
Report for Contract Year 2005**



**External Quality Review Organization
Annual Report**



**Submitted by
HCE QualityQuest, Incorporated
Phoenix, Arizona**

**EQRO Annual Report
Contract Year 2005
Children's Rehabilitative Services Administration**

EXECUTIVE SUMMARY

I. INTRODUCTION

II. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE MEASURES

III. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE IMPROVEMENT PROJECTS

- A. Objectives
- B. Description of Data Collection Methodology
- C. Description of Data
- D. Review of Analysis Methodology
- E. Assessment of Strengths and Weaknesses
- F. Conclusions
- G. Contract Year Ending 2005 Update

IV. REVIEW, ANALYSIS, AND SUMMARY OF CRS ADMINISTRATION COMPLIANCE WITH MEDICAID MANAGED CARE FEDERAL AND STATE REGULATIONS

- A. Objective
- B. Description of Data and Information Collection Methodology
- C. Description of Data and Information
- D. Review of Analysis Methodology
- E. Assessment of Strengths and Weaknesses
- F. Conclusion

V. SUMMARY AND RECOMMENDATIONS

BIBLIOGRAPHY

EXECUTIVE SUMMARY

The purpose of this EQRO Annual Report is to evaluate the Children's Rehabilitative Services Administration's (CRSA's) compliance with the Balanced Budget Act of 1997 (BBA) requirements applicable to CRSA as a prepaid inpatient health plan (PIHP). The review is limited to three areas: performance measures, performance improvement projects, and compliance with Medicaid managed care federal and state regulations.

The CRS program is administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OSCHN). CRSA provides a limited scope of services to children who have certain medical, disabling, or potentially disabling conditions which have the potential for functional improvement. The most common conditions are cerebral palsy, congenital circulatory problems, and congenital musculoskeletal deformities. AHCCCS eligible CRS children are concurrently enrolled in an AHCCCS Acute Care/Arizona Long Term Care System (ALTCS) Contractor, for their primary health care needs. CRS recipients are included in the acute care or ALTCS plan population from which samples are drawn for acute care or ALTCS plan performance measures. Therefore, AHCCCS has not included CRSA in its performance measurement process. However, beginning with the contract renewal effective July 1, 2005, AHCCCS has identified three performance measures that CRSA will monitor and report.

CRSA also is not included in the mandatory performance improvement projects designed by AHCCCS, since these are usually focused on primary care services that are not part of the scope of services provided by CRSA. However, CRSA is required to develop its own performance improvement projects. One new project is required each contract year. Projects must be approved by AHCCCS prior to implementation. Guidelines for performance improvement projects are included in the *AHCCCS Medical Policy Manual (AMPM)*, and participation in performance improvement projects is a contract requirement.

Three proposals, identified by CRSA as performance improvement projects, in varying stages of completion, were reviewed for the CYE 2004 EQRO Annual Report. No new PIP data or projects were reported for CYE 2005. An update for the three previous projects is provided in this report. The following are the three CRSA projects that have been updated.

- Increase Appropriate Cleft Lip/Cleft Palate Follow-up Visits
- Increase Accuracy of WeeFIM Assessments
- Improve Pediatric to Adult Transition Services for Youth

Although topics and projects selected by CRSA have the potential to positively impact quality of care, functional status, and recipient satisfaction, proposed PIPs have consistently failed to demonstrate an impact on these potential outcomes. CRSA has a history of starting PIPs and not completing them, primarily because they were poorly designed. CRSA requested and was granted an exemption from completing the Cleft

Lip/Cleft Palate performance improvement project and requested it be allowed to discontinue the WeeFIM performance improvement project. As a result of the ongoing difficulties experienced by CRSA in completing performance improvement projects, beginning in CYE 2006, AHCCCS has mandated a specific performance improvement project and included the methodology for conducting and completing the project in its contract with CRSA. CRSA also will be required to perform an additional self-selected performance improvement project each year.

AHCCCS has a written *Quality Assessment and Performance Improvement Strategy* to comply with the BBA requirement. On a regularly scheduled basis, AHCCCS monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measures, and performance improvement outcomes. This monitoring is accomplished through ongoing report and document review, regular meetings with CRSA staff, and an annual on-site operational and financial review (OFR). The process is thorough, complete, and well documented by AHCCCS. Despite the close monitoring, frequent meetings, continuous feedback, and technical assistance provided by AHCCCS, CRSA has been slow to demonstrate measurable improvement. The corrective action plans submitted by CRSA in response to identified difficulties are either not implemented or not documented. AHCCCS now meets with CRSA on a regularly to follow-up on corrective action plan activities. CRSA is unable to document adequate oversight of its four regional contractors and has made minimal progress in complying with federal and state requirements.

At the time of this review, AHCCCS had just issued a Notice to Cure to CRSA. The Notice to Cure process is used by AHCCCS prior to imposing sanctions for noncompliance with contract requirements. Significant quality of care concerns are what prompted the Notice to Cure. Some issues such as staffing, committee structure and oversight of delegated functions are longstanding problems that CRSA has left uncorrected for years. The Notice to Cure should help focus CRSA's attention on these critical areas.

I. INTRODUCTION

Arizona's Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS), commenced in 1982 and was the first Medicaid program in the United States to be granted an 1115 Waiver. This waiver refers to a certain provision of the Social Security Act that outlines specific requirements for Medicaid. The waiver allows Arizona to operate a demonstration project using a managed care model for delivery of health care services.

Arizona has a longstanding program known as Children's Rehabilitative Services (CRS). CRS previously was known as the Arizona Society for Crippled Children, which was founded in 1929 as a private, charitable organization caring for poor children suffering from the effects of poliomyelitis and other conditions, such as club foot. In 1935 the Social Security Act provided federal money to be used by Arizona for the operation of Crippled Children's Services. The Children's Rehabilitative Services program is currently administered through the Arizona Department of Health Services (ADHS), Division of Public Health Services/Office for Children with Special Health Care Needs (DPHS/OCSHCN). Historically, the CRS program operated essentially independent of any significant oversight by AHCCCS. However, in recent years with implementation of the Balanced Budget Act, AHCCCS has assumed a much more active role. If a child is Medicaid eligible and receives covered services from CRS, then AHCCCS is ultimately responsible for payment, which is made through a capitation methodology. The Arizona Department of Health Services (ADHS)/Office for Children with Special Health Care Needs (OCSHCN) is responsible for administration and oversight of the program.

It is important to note that all Medicaid eligible children are assigned to an AHCCCS Acute Care/ALTCS Contractor for their episodic, EPSDT, and other health care needs. However, for those specifically defined conditions covered by CRS, services are provided through a network of four CRS regional contractors (clinics). The regional contractors are located in Flagstaff, Phoenix, Tucson and Yuma. These entities are responsible for establishing a network of providers, therapists, and other appropriate facilities and services to meet the care needs related to the covered conditions of eligible CRS recipients within their contracted geographic service area (GSA). When a child is identified with a CRS covered condition, the child is referred by the Acute Care/ALTCS Contractor to a CRS clinic. The child must be evaluated by the clinic and, if the clinic verifies that the condition qualifies for CRS coverage, the child must receive all care for that condition from the clinic and its contracted provider network. As a result, all Medicaid enrolled children with a qualifying handicapping condition are essentially enrolled in two health care systems.

Under the Balanced Budget Act (BBA) of 1997, CRS is classified as a prepaid inpatient health plan (PIHP) and therefore is accountable for evaluating, measuring, and ultimately improving the quality of care delivered to members. AHCCCS modified its contract with ADHS/CRS to include those elements that are required to be monitored and measured. Contractual modifications required a significantly higher level of oversight and accountability for both agencies.

Each Medicaid eligible child in CRS also is assigned to an Acute Care/ALTCS Contractor, and is included in that plan's performance improvement projects and performance measures. As a result, CRSA is in a unique position. The standard performance improvement projects and performance measures mandated by AHCCCS for the Acute Care/ALTCS Contractors have been based on traditional HEDIS® measures, such as immunization rates and well-child visits. These are not services provided by CRS. Therefore, the performance improvement projects required of CRSA have been self-selected and specific performance measures have not been contractually required. This changed with the contract renewal effective July 1, 2005. AHCCCS has identified specific performance measures for CRSA and has identified the methodology for a specific performance improvement project to begin this year.

The BBA of 1997 requires for review by the State of health plan compliance with federal and state law regarding managed care systems every three years, and also requires an annual External Quality Review Organization (EQRO) report. AHCCCS contracted with HCE QualityQuest to perform this EQRO Annual Report for CRSA for contract year 2005. This report is limited to a review of three areas: performance measures, performance improvement projects, and compliance with federal and state regulations.

II. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE MEASURES

Arizona Health Care Cost Containment System (AHCCCS), as described in its Quality Assessment and Performance Improvement Strategy, recognizes the need for identifying, tracking, and trending performance measures (indicators) as a component of assessing the overall quality of care delivered to its members. AHCCCS also recognizes, for these measures to be reliable and valid, that the methodology used must be sound and based on nationally recognized standards. AHCCCS, with minor modifications, uses the Health Plan Employer Data and Information Set (HEDIS[®]) to measure performance in its acute care plans. HEDIS[®] was developed by the National Committee for Quality Assurance (NCQA) and first released in 1993. It is considered the national standard for measuring and reporting health plan performance.

In addition to identifying the performance indicators to be measured, AHCCCS also identifies a minimum performance standard, a goal, and a benchmark for each indicator. The benchmarks are based on the goals for health promotion and disease prevention developed by the U.S. Department of Health and Human Services as part of its Healthy People 2000 or 2010 publication. Acute Care/ALTCS Contractors are contractually required to participate in performance measures. Contractors that do not meet the minimum standards must submit a corrective action plan for review and approval by AHCCCS. All health plans are expected to continuously improve their performance measures.

Medicaid eligible CRS recipients are enrolled in the AHCCCS program and assigned to an Acute Care/ALTCS Contractor for their primary health care needs. CRSA is only responsible for services directly related to a specific condition, such as spina bifida or cerebral palsy. The Acute Care/ALTCS Contractor is ultimately responsible for the delivery of all medically necessary health care services. CRS recipients are included in the Acute Care/ALTCS Contractor population from which samples are drawn for Contractor performance measures. For example, when measuring immunization rates for two year old children, all two-year-old children may be included in the sample, even those with spina bifida or cerebral palsy receiving specialized services through CRSA.

Because CRS recipients are concurrently enrolled in an Acute Care/ALTCS Contractor, the performance measurement process established for Acute Care/ALTCS Contractor is not applicable, and until now CRSA has not been required to participate in the performance measurement process. CRSA has produced reports that it refers to as performance measures, but these have historically been standard utilization management reports. Beginning July 1, 2005 (CYE 2006), AHCCCS has included in its contract renewal with CRSA three performance measures that CRSA must report on annually.

- Preliminary determination of medical eligibility
- Timeliness of initial evaluation
- First appointment with CRS specialty provider

These measures are unique to the CRS program and are reflective of the services provided by CRSA. AHCCCS has delineated the methodology to be used and established minimum performance standards for each measure. Data for these performance measures will be included in future EQRO reports beginning CYE 2006.

III. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE IMPROVEMENTS PROJECTS

Performance Improvement Projects (PIPs) are part of the overall AHCCCS Quality Assessment and Performance Improvement Strategy. The requirement to design and implement performance improvement projects is included in the AHCCCS contract with CRSA. The guidelines for conducting PIPs are detailed in the *AHCCCS Medical Policy Manual* (AMPM), Policy 980 in Chapter 900. The *AHCCCS Medical Policy Manual* complies with the protocols published by the Centers for Medicare and Medicaid Services. These protocols state that “The purpose of PIPs is to assess and improve processes, and thereby, outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted and reported in a methodologically sound manner.”¹

As required in 42 CFR 438.236, performance improvement projects shall include the following components.

- Identify clinical or non-clinical areas for improvement
- Gather baseline data from administrative data and other sources
- Design and implement interventions
- Measure the effectiveness of the intervention
- Maintain and sustain the improvement

Performance improvement projects are intended to take four years to complete. AHCCCS requires, at the end of the first year, that a baseline measurement be established. In the second year, the emphasis is on intervention. A re-measurement to determine if improvement has been made is conducted in the third year. If improvement is demonstrated, measurement is repeated in the fourth year documenting sustained improvement. AHCCCS requires all contractors to submit, on an annual basis, a quality management and evaluation plan. The QM plan is the vehicle used to propose new PIPs and provide updates and progress reports on those in process. AHCCCS must approve all PIP proposals prior to implementation. AHCCCS incorporated the following steps into a tool for Quality Management staff to use in reviewing PIP proposals.

- Review the selected study topic(s)
- Review the study question(s)
- Review selected study indicator(s)
- Review the identified study population
- Review sampling methods (if sampling was used)
- Review the MCO/PIHP's data collection procedures
- Assess the MCO/PIHP's improvement strategies
- Review data analysis and interpretation of study results
- Assess the likelihood that reported improvement is “real” improvement
- Assess whether the MCO/PIHP has sustained its documented improvement

Three proposals identified by CRSA as performance improvement projects, in varying stages of completion, were reviewed for the CYE 2004 EQRO Annual Report. This report will provide an update on those projects.

- Increase Appropriate Cleft Lip/Cleft Palate Follow-up Visits
- Increase Accuracy of WeeFIM Assessments
- Improving Pediatric to Adult Transition Service for Youth

Each of the three performance improvement projects will be discussed separately.

Increase Appropriate Cleft Lip and/or Cleft Palate Follow-up Visits

A. Objectives

The proposal for this PIP was submitted in December 2002 and approved by AHCCCS in March, 2003. The purpose of this project was to determine the percentage of CRS recipients with cleft lip and/or cleft palate, between two and three years of age, who had a dental visit in the previous contract year. Most children with cleft lip and/or cleft palate have associated dental anomalies that may adversely affect normal growth and development. Early intervention may limit potential negative outcomes. CRSA Guidelines to Care for Cleft Lip/Palate require Regional Contractors to have all children, between two and three years of age, be evaluated by a dental provider.²

B. Description of Data Collection Methodology

The study question is “What is the percentage of children between the ages of two and three who have a diagnosis of cleft lip and/or cleft palate being screened by a pediatric dentist?” The study indicator is worded exactly as is the study question. The indicator criteria define the HCPCS codes used to identify a dental visit and describe the age parameters used in data collection. However, no enrollment criteria are defined, such as length of time in the program, or whether individuals included in the study population are enrolled in the AHCCCS program.

The denominator is defined as the number of children receiving services through CRSA (overall and by individual Regional Contractors) who had a diagnosis of cleft lip and/or cleft palate (ICD-9 codes 749.00 through 749.24), who turned age three during the review period.³ The denominator includes ICD-9 codes and age parameters. The numerator is defined as the number of children in each denominator who had a dental visit between their second and third birthday.⁴

The CRSA encounter/claims system is identified as the sole source for data collection. No lag time was built into the data collection design. The data collected was based on percentages and reported by Regional Contractor and in the aggregate. A chi-squared analysis was planned to evaluate the significance of change from year-to-year. The

baseline report, submitted in December 2003 by CRSA, identified barriers to performing the study, such as information not being available in the CRSA data system and services potentially being provided by other insurance plans. The goal established was that 85% of CRS recipients with cleft lip and/or cleft palate will have a dental evaluation between the age of two and three years. Improvement strategies also were identified in the baseline report.

As a result of ongoing monitoring and technical assistance provided by AHCCCS to CRSA, a revised PIP methodology for the cleft lip/cleft palate study was submitted to and approved by AHCCCS in July of 2004. The revised methodology was to include a two question telephone survey of parents to determine if the child had received dental services. This would eliminate the need for encounter data and avoid some of the previously identified data collection problems.

C. Description of Data

The only data provided to date are the baseline report, which was measured from 07/01/2002 to 06/30/2003. The findings are summarized in Table 1.

Table 1
Children with Cleft Lip and/or Cleft Palate with a Dental
Visit Between 2 and 3 Years of Age

Region	Numerator	Denominator	Percent
Northern Region	1	16	6.3%
Central Region	7	130	5.4%
Southern Region	5	50	10.0%
Western Region	0	9	0.0%
Statewide	13	205	6.3%

D. Review of Analysis Methodology

A presentation of the baseline data was the only review completed at the time of this EQRO Annual Report. The findings were significantly lower than the established goal. The analysis was limited to potential additional sources of data, such as from AHCCCS. CRSA does not address the potential reasons for encounters being so low. For example, were referrals not made, appointments not kept, or encounters recorded at the Acute Care/ALTCS Contractor in which the CRS recipient is enrolled for his/her primary health care.

Documents related to the history of this PIP demonstrate ongoing review of the study design and methodology by AHCCCS and CRSA. These reviews, combined with ongoing discussions between AHCCCS and CRSA, demonstrate efforts to improve the study design.

E. Assessment of Strengths and Weaknesses

The impact of early intervention on mitigating the impact of dental anomalies in children with cleft lip/cleft palate is unquestioned. A PIP designed to ensure that early intervention occurs would be appropriate and clearly linked to quality. The interventions would lead to improving the functional status and satisfaction of CRSA recipients with cleft lip and/or cleft palate, and their families. For example, nutrition would be improved by the ability to chew a variety of foods, which would have a positive impact on growth. Speech also would be improved, allowing for improved oral communication. Both would have a positive impact on recipient satisfaction and general growth and development. The proposal, as presented, did not attempt to look at outcomes or improving health status, functional status, or recipient satisfaction over time. Another weakness of the proposal is its reliance on encounter data in the initial design. A program with a population that has more than one source of care for the same services cannot use encounter data from only one place as a reliable source of information.

No documentation or discussion was included on how this PIP topic was selected and approved by CRSA. No reference is made to the AHCCCS required committee approval process, and there is no mention of medical director involvement.

F. Conclusions

According to utilization data included in the CY 2004 QM/UM Plan, cleft lip and/or cleft palate affects 7.46% (1,301) of the 17,440 children in the CRSA population. Most of the cleft lip and/or cleft palate children visit a dentist between four and nine years of age, and most dental procedures occur between 10 and 14 years of age. Only 11 encounters were reported for children between one and three years of age. Since the study population was an even smaller subset of the one to three year age group, it would be expected that dental encounters for the two to three year old age group with cleft lip and/or cleft palate would be low. Since the purpose of a PIP is to improve a process, and thereby outcomes, the utilization data cited support the development of a PIP to address this area and improve adherence to the CRSA care guidelines. CRSA might have focused earlier in the project on identifying alternative data sources to ensure reliable, valid conclusions.

While AHCCCS did approve the study proposal, it did not accept the baseline report or the interim report submitted by CRSA. AHCCCS requested that CRSA re-design the project to bring it into compliance with AHCCCS policy and contract requirements. AHCCCS held several meetings with CRSA Quality Management staff to guide them in the PIP development process. A review of this performance improvement project was included in the CRSA CYE 04 Operational and Financial Review. A specific recommendation from the OFR required CRSA to re-design this project. CRSA submitted a new proposal as part of the corrective action plan.

G. CYE 2005 Update

AHCCCS approved the revised methodology for this PIP and the new reporting timeline in July of 2004. CRSA did not complete the project and requested to be relieved of responsibility for the PIP. After much internal debate, AHCCCS agreed that CRSA should focus on its more current performance improvement projects and not expend any more resources on this PIP.

Increase Accuracy of WeeFIM Assessments

A. Objectives

This PIP proposal was submitted in December 2003 and reviewed by AHCCCS in January 2004, with only minor recommended changes to the timeline. The purpose of this PIP was to allow CRSA to maximize use of the WeeFIM system. Wee refers to the children's version of the FIM, or Functional Independence Measure. The WeeFIM system is part of the Uniform Data System for Medical Rehabilitation (UDSMR) and was developed with input from a number of national organizations, such as the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation. The UDSMR's mission is to enable health care providers to document the outcomes, processes, and perceptions of care in a uniform way.⁵ CRSA requires its Regional Contractors to complete a WeeFIM form at specified intervals for children with spina bifida, cerebral palsy, and pre-op and/or post-op rhizotomy procedures. CRSA's ability to use the system is dependent on Regional Contractors submitting the completed forms.

B. Description of Data Collection Methodology

The study question is "What is the percentage of clean assessments submitted to Arizona Department of Health Services/Office for Children with Special Health Care Needs (ADHS/OCSHCN)." Critical features of the study, such as the WeeFIM tool, spina bifida, cerebral palsy, and pre-op/post-op rhizotomy procedures, are not included in the study question. The study indicator is worded almost the same way as the study question.

The study population included children currently receiving services through the CRSA program with a diagnosis of spina bifida, cerebral palsy, or a pre-op/post-op rhizotomy procedure. The ICD-9 codes used were not identified. Children with a rhizotomy procedure are a subset of those with cerebral palsy; the potential for duplication exists. There is no indication that enrollment in the AHCCCS program, age, or minimum enrollment periods, were considered.

There is no documentation to explain how this topic was selected, how it was reviewed and approved, or by whom. No reference is made to the AHCCCS required committee approval process, and there is no mention of medical director involvement.

C. Description of Data

All data for this project were obtained from the ADHS/OCSHCN WeeFIM data system. The data presented in the baseline and interim report included the number and percentage of clean WeeFIM assessments submitted by the Regional Contractors to CRSA. These findings are summarized in Table 2.

Table 2
The Percentage of Clean WeeFim Assessments Submitted to ADHS

Regional Contractors	Measurement	Time Period	Numerator	Denominator	Percentage
Northern (Flagstaff)	Baseline	Fiscal Year 2003	3	44	6.8%
	Measurement 1	April, May, June 2004	11	11	100.0%
Central (Phoenix)	Baseline	Fiscal Year 2003	238	811	29.3%
	Measurement 1	April, May, June 2004	92	92	100.0%
Southern (Tucson)	Baseline	Fiscal Year 2003	400	413	96.8%
	Measurement 1	April, May, June 2004	43	43	100.0%
Western (Yuma)	Baseline	Fiscal Year 2003	9	70	12.8%
	Measurement 1	April, May, June 2004	17	17	100.0%
Statewide	Baseline	Fiscal Year 2003	650	1338	48.5%
	Measurement 1	April, May, June 2004	163	163	100.0%

D. Review of Analysis Methodology

The analysis plan, as presented in the proposal, is simply a reiteration of the data collection process. No analysis was performed. No assessment or discussion of the accuracy of the WeeFIM assessments was included in the proposal, nor was there mention of how the tool is used or its proposed impact on health outcomes.

E. Assessment of Strengths and Weaknesses

The WeeFIM system was developed by the Uniform Data System for Medical Rehabilitation. The WeeFIM System documents functional performance in children and adolescents with acquired or congenital disabilities and provides a method of evaluating outcomes for individual patients, groups of patients, and pediatric rehabilitation and habilitation programs.⁶ CRSA requires its contractors to participate in the WeeFIM Functional Independent Measurement System. Assessments are to be performed at specific intervals on the same individual over time. As a functional outcome measurement system, WeeFIM was adopted by CRSA to assist in program evaluation. It is not clear how long the system has been in use by CRSA or what it does with the data and reports generated by the system. How CRSA uses WeeFIM assessments to impact health outcomes or enrollee satisfaction is not discussed in the PIP proposal or follow-up reports.

The only intervention identified in the interim report was the purchase of a UDSMR system upgrade that allowed for real time direct entry of data into the WeeFIM system. This upgrade resulted in 100 % completion of forms.

CRSA now had the information needed to begin assessing functional improvement of its recipients with spina bifida and cerebral palsy over time. This was the point at which the substantive work related to performance improvement should have begun. Instead, CRSA proposed that this PIP had been completed.

F. Conclusions

After a baseline measurement and one follow-up measurement, CRSA reported 100% compliance with its contractors completing a WeeFIM assessment and expected that the project would end. Ending the project at this point demonstrates a lack of understanding of the purpose and intent of performance improvement projects, as each project is intended to occur over a three to four year period. The Background and Purpose sections of the PIP proposal could be improved to more clearly state the connection between completeness/accuracy of the WeeFIM data and functional status or quality of care. Although the title of the project is “Increase Accuracy of WeeFIM Assessments,” accuracy in completing the assessment tool is not addressed. The study focuses solely on whether the form is filled out, not whether the information is accurate or used to impact quality of care in any way.

This project was limited to measuring the percentage of completed assessments submitted to the system and did not clarify the link between completed assessments and outcomes. AHCCCS did approve the proposal and, in a letter dated October 21, 2004, AHCCCS indicated that the October 20, 2004 interim report for this project was received. AHCCCS planned to respond with comments as part of its overall response to the proposed CYE 2005 Quality Management/Utilization Management Annual Plan.

G. CYE 2005 Update

In February 2005, AHCCCS asked CRSA to revise the report and identified four recommendations. CRSA was also told that the project was not completed and that it must continue with the re-measurement and reevaluation process. In June of 2005, it appears that CRSA unilaterally decided not to complete this performance improvement project. This is evident in a letter from AHCCCS to CRSA where the following is noted:⁷

CRSA did not request that AHCCCS consider relieving CRSA from its contractual obligation to complete this PIP, but has simply advised AHCCCS of its decision to discontinue the project and implemented the decision without approval from AHCCCS. It should be noted that AHCCCS has already excused CRSA from completion of another PIP due to CRSA's inability to collect data and follow through with subsequent agreements.

In July 2005, CRSA argued that the WeeFIM tool is not an adequate tool for assessing the functional status of children with spina bifida and cerebral palsy. CRSA has identified a more sensitive tool and wants to revise the PIP. In an August 2005 letter, AHCCCS told CRSA to revise the PIP methodology and submit it for approval by October 1, 2005. A further update on this performance improvement project will be included in the CYE 2006 EQRO Annual Report.

Improving Pediatric to Adult Transition Services for Youth

This proposal was submitted by CRSA in December 2004. In February 2005, AHCCCS requested numerous changes to the methodology and made several recommendations. During the course of the following year AHCCCS worked with CRSA to revise the methodology for this project. After several attempts by CRSA, AHCCCS drafted the methodology and incorporated it in the upcoming contract renewal. As a result, no data was available for review this contract year. The following description applies to the original proposal submitted by CRSA; it will be updated to reflect the contract revision in the next EQRO annual report.

A. Objectives

The purpose of this project is to improve transition services for adolescents receiving services through CRSA. Transition planning allows young people to optimize their ability to function as adults. CRSA requires its Regional Contractors to initiate transition services for recipients at 14 years of age. This project was designed to determine the percentage of children who have documented transition plans initiated and to develop interventions aimed at eliminating the barriers to providing these services when identified.

B. Description of Data Collection Methodology

Three study questions were identified in this PIP proposal.

- What percentage of CRS recipients have a transition plan initiated and documented by age 15 years within the study period?
- What are the barriers to the initiation of transition planning and documentation?
- How do the percentages compare by CRSA contractor site?

While more than one study question is acceptable in a project, each must have a defined indicator to answer the question. However, for this PIP, only one study indicator is identified. The indicator defines what documentation must be present to be valid. However, the study indicator does not address outcomes, such as health or functional status, recipient satisfaction, or valid proxies of these outcomes.

The study population, as described, includes CRS recipients enrolled in AHCCCS who reached 15 years of age by June 30, 2005 and had at least one encounter from July 1, 2004 to June 30, 2005. The sample selection states that all CRS recipients who meet these criteria will be included in the study.

The denominator is defined as CRS recipients between 15 and 16 years of age on June 30, 2005, who had at least one encounter from July 1, 2004 to June 30, 2005.

The numerator is defined as the number of CRS recipients from the denominator who had a documented transition plan initiated within the study period.

The study population, sample selection, denominator, and numerator are consistently defined. However, the data collection section states that a random sample will be extracted from CRSA contractor databases, which is inconsistent with what is described in the sample frame. Further clarification of the sample selection was needed. AHCCCS worked closely with CRSA to refine the sample selection process.

The data collection plan includes a combination of administrative data and medical record abstraction. No information is provided to define the administrative data. A tool for medical record abstraction has been developed. A plan for data validation is described, including education to ensure inter-rater reliability.

The staff to be used in data collection are not described. The analysis plan describes how the baseline data will be obtained and comparisons made between Regional Contractors. Barrier analysis and focus groups are discussed, but the methodologies to be used have not been developed yet.

C. Conclusions and CYE 2005 Update

AHCCCS worked very closely with CRSA on refining the methodology for this PIP. The methodology for this PIP has been incorporated into the July 1, 2005 CRSA contract renewal. CRSA will provide its baseline measurement to AHCCCS and implement interventions during CYE 2006. This represents the first performance improvement project where the methodology is defined by AHCCCS and incorporated into the contract. It appears that AHCCCS has accepted the leadership role for developing the methodology for CRSA performance improvement projects. This may result in the first performance improvement project completed by CRSA. This PIP has the potential to serve as a model for future performance improvement projects proposed by CRSA.

Notes

¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003, p. 1.

² Arizona Department of Health Services, Office for Children with Special Health Care Needs, Quality Improvement Project Methodology Increase Cleft Lip/Cleft Palate Follow-up Visits, p. F-2.

³ ADHS/OCSHCN, p. F-3.

⁴ ADHS/ OCSHCN, p. F-4.

⁵ UDSMR, Uniform Data System for Medical Rehabilitation, as of April, 2005.
http://www.udsmr.org/udsmr_missionstatement.php

⁶ UDSMR, WeeFIM System, Product Information, as of April 2005.
http://www.udsmr.org/pdfs/2005_WeeFIM_II_Product_Information_Slick.pdf

⁷ AHCCCS, “To Arizona Department of Health Services, Office for Children with Special Health Care Needs, Children’s Rehabilitative Services,” 3 June 2005, Completion of WeeFIMS Performance Improvement Project.

IV. REVIEW, ANALYSIS, AND SUMMARY OF CRSA COMPLIANCE WITH MEDICAID MANAGED CARE FEDERAL AND STATE REGULATIONS

A. Objective

The Balanced Budget Act of 1997 (BBA) requires Medicaid agencies that contract with Medicaid managed care organizations (MCOs) “to develop a state quality assessment and improvement strategy that is consistent with standards established by the Department of Health and Human Services (DHHS).”¹ AHCCCS has a written Quality Assessment and Performance Improvement Strategy to comply with the BBA requirement. The document was developed with input from members, the public, and other stakeholders. The document is reviewed annually and/or when a significant change occurs. AHCCCS reports Quality Strategy activities, findings, and actions to members, other stakeholders, contractors, the governor, legislators, and the Center for Medicare & Medicaid Services (CMS).² BBA provisions also apply to prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management programs (PCCMs). CRSA is classified as a prepaid inpatient health plan (PIHP). In recognition of this, the AHCCCS contract with CRSA has been modified over time to comply with these requirements. Federal requirements are broadly defined under the following categories.

- Enrollee Rights and Protections
- Quality Assessment and Performance Improvement
 - Access Standards
 - Structure and Operations Standards
 - Measurement and Improvement Standards
- Grievance System

B. Description of Data and Information Collection Methodology

On a regularly scheduled basis, AHCCCS monitors and evaluates CRSA compliance with access to care, organizational structure and operations, clinical and non-clinical quality measurements, and performance improvement outcomes through the following activities.

- Annual on-site operational and financial reviews
- Review and analysis of periodic reports
- Review and analysis of program specific performance indicators and Performance Improvement Projects³

The contract between AHCCCS and CRSA contains the following list of periodic reporting requirements.

Periodic Reporting Requirements

Report	When Due
Quarterly Financial Report	60 days after the end of each quarter
Certification Statement	With each Quarterly and Annual Report
Draft Annual Audit Report	90 days after the end of each fiscal year
Draft Management Letter	90 days after the end of each fiscal year
Final Annual Audit Report	120 days after the end of each fiscal year
Final Management Letter	120 days after the end of each fiscal year
Accountant's Report on Compliance	120 days after the end of each fiscal year
Reconciliation – Annual Audit and Plan Year-to-Date Financial Report Information	120 days after the end of each fiscal year
Financial Disclosure Report	120 days after the end of each fiscal year
Encounter Data – Magnetic Tape Submission	Monthly, according to established schedule
Corrected Pended Encounter Tape	Monthly, according to established schedule
New Day Tape	Monthly, according to established schedule
Medical Records for Data Validation	90 days after the request is received from AHCCCS
Quarterly Grievance Report	45 days after the end of each quarter
Quality Management/Utilization Management Plan and Evaluation	Annually on December 15 th
Quality Improvement Project (QIP) Proposal (initial/baseline year of project)	Annually on December 15 th
QIP Interim Report (intervention/ measurement year(s) of the project)	Annually on December 15 th
Provider Fraud/Abuse Report	Immediately following discovery
Eligible Person Fraud/Abuse Report	Immediately following discovery
Cultural Competency Plan	45 days after the first day of a new contract year
Written Description of Covered Services	Annually on July 1 st or upon revision
Clinic Contact List	Quarterly on July 1 st , October 1 st , January 1 st . and April 1 st
Revised Member Handbook	Annually on June 1 st , or within 4 weeks of receiving the annual contract renewal, whichever is later
Provider Network Development and Management Plan	45 days after the first day of a new contract year

These reports are reviewed by AHCCCS on an ongoing basis within the department responsible for the area of the reports. In addition to these reports, the contract also requires CRSA to submit the following documents to AHCCCS for review and approval.

- A CRSA Policy Manual, with copies of final policies submitted to AHCCCS at least ten business days prior to implementation
- Physician Incentive Plan Disclosures
- All subcontracts for the provision of AHCCCS covered services
- Requests for Proposals to provide AHCCCS covered services
- Legislative Proposals and Initiatives – CRSA shall provide AHCCCS with copies of proposals for legislative changes, Arizona Administrative Code program initiatives, and any other policy initiatives that may affect CRSA services, coverage, or any aspects of medical care

Upon receipt by AHCCCS, the documents listed above are forwarded to the department at AHCCCS that has the expertise needed to analyze the content of the document. Where applicable, checklists have been developed for staff to use in the review process, ensuring that all required federal and state requirements are addressed. AHCCCS responds in writing, and either approves the document or requests revisions.

The data and information used in the review process are the actual documents used in daily operations. For example, a CRSA recipient information packet ready for mailing, an actual signed provider contract, the actual grievance log, authorization logs, and reports produced by CRSA staff are reviewed. Mock-ups are not accepted.

In addition to reviewing the deliverables described above, AHCCCS conducts an on-site review annually. The on-site review allows AHCCCS the opportunity to review and validate CRSA compliance with contract requirements. AHCCCS refers to these on-site reviews as Operational and Financial Reviews (OFRs). The process used for these reviews has been refined over several years. A uniform tool is used to review each Acute Care/ALTCS Contractor and, when possible, the same staff is assigned to conduct the review. This process is designed to ensure consistency. The format of the review follows nationally recognized processes and is modeled after NCQA.

The actual on-site activities include document review, staff interviews, and observations of operations. In this way, the review staff is able to get a complete picture of CRSA performance. This process is consistent with the protocol developed by CMS that includes the following recommended activities.

- Planning for the review
- Obtaining background information
- Document review
- Conducting interviews
- Collecting accessory information
- Reporting results

For contract year 2005, AHCCCS identified the following objectives for the CRSA Operation and Financial Review.⁴

- Determine if CRSA satisfactorily meets AHCCCS' requirements as specified in the Contract Year Ending 2005 (CYE 05) contract, AHCCCS policies and the Arizona Administrative Code (AAC).
- Increase AHCCCSA knowledge of CRSA's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior Operational and Financial Reviews.
- Determine if CRSA is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
- Perform oversight of CRSA as required by the Centers for Medicare & Medicaid Services in accordance with AHCCCS' 1115 waiver.
- Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR Part 438.364.

Upon completion of the Operational and Financial Review, key program areas are scored, based on the following scale.

- | | |
|--------------------------|------------------------------------|
| • Full Compliance | 90-100% agreement with standard(s) |
| • Substantial Compliance | 75-89% agreement with standard(s) |
| • Partial Compliance | 50-74% agreement with standard(s) |
| • Non-Compliance | 0-49% agreement with standard(s) |

A written report that includes findings and recommendations is then produced. Recommendations are made based on the following definitions.

- **CRSA must...**This indicates a critical non-compliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- **CRSA should...**This indicates a non-compliance area that must be corrected to be in compliance with the AHCCCS contract, but it is not critical to the everyday operation of CRSA.
- **CRSA should consider...**This is a suggestion by the Review Team to improve operations of CRSA, although it is not directly related to contract compliance.

C. Description of Data and Information

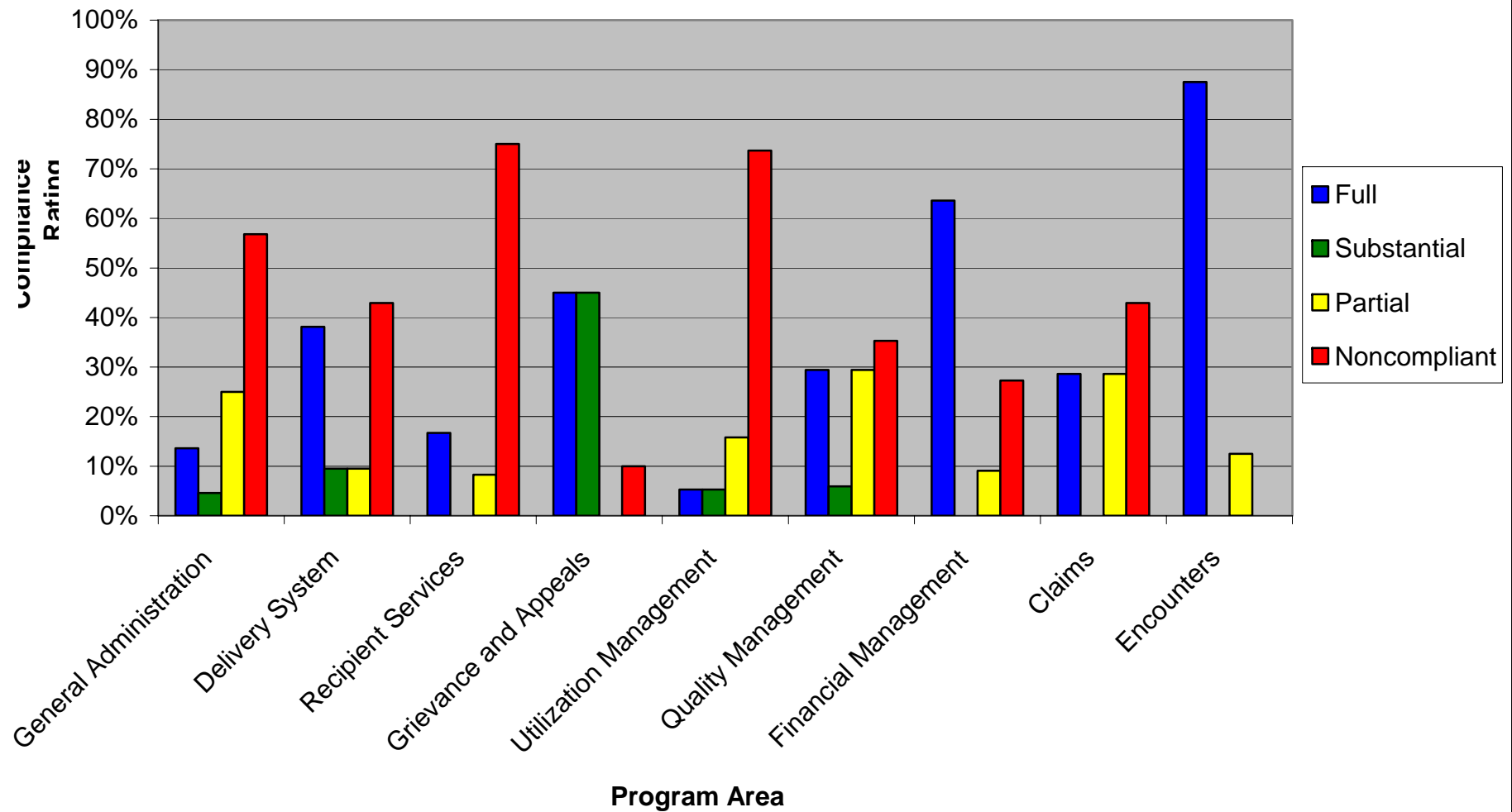
A summary of the findings for the Operational and Financial Review of CRSA for CYE 05 is displayed in Table 3 and Figure 3.

Overall, 159 standards were reviewed and scored. An additional six standards were reviewed for information only and six standards were non-applicable. These were not included in the scoring process and were not included in the findings displayed in Table 3 and Figure 3.

Table 3
Summary of CRS CYE 2005 OFR Findings

Program Areas	Number of Standards Reviewed	Compliance Rating for Standard			
		Full	Substantial	Partial	Noncompliant
General Administration	44	(6) 13.6%	(2) 4.6%	(11) 25%	(25) 56.8%
Delivery System	21*	(8) 38.1%	(2) 9.5%	(2) 9.5%	(9) 42.9%
Recipient Services	12*	(2) 16.7%	(0) 0%	(1) 8.3%	(9) 75%
Grievance and Appeals	20	(9) 45%	(9) 45%	(0) 0%	(2) 10%
Utilization Management	19	(1) 5.3%	(1) 5.3%	(3) 15.8%	(14) 73.7%
Quality Management	17*	(5) 29.4%	(1) 5.9%	(5) 29.4%	(6) 35.3%
Financial Management	11	(7) 63.6%	(0) 0%	(1) 9.1%	(3) 27.3%
Claims	7*	(2) 28.6%	(0) 0%	(2) 28.6%	(3) 42.9%
Encounters	8*	(7) 87.5%	(0) 0%	(1) 12.5%	(0) 0%
Total	159	(47) 29.6%	(15) 9.4%	(26) 16.4%	(71) 44.7%
* excludes standards reviewed for "Information Only" and "Not Applicable"					

Figure 3: Summary of CRS CYE 2005 Findings



D. Review of Analysis Methodology

In its oversight of CRSA, AHCCCS uses a combination of methods designed to complement each other and provide as complete a picture as possible of CRSA operations. At least annually, AHCCCS reviews and approves, or requests revisions to, critical written materials used by CRSA in fulfillment of its contract. Examples of these materials are listed below.

- Recipient handbook
- Network evaluation and management plan
- Quality Management evaluation and plan
- Cultural Competency evaluation and plan

These documents are formally reviewed and a written response provided to CRSA. Checklists are used to ensure that all required elements are included in the review. Staff with content expertise is used in the review process. Regular meetings are held with CRSA staff to continuously review and monitor progress in selected areas, such as quality management and performance review projects. In addition to review and monitoring, these meetings provide a forum for ongoing education, technical assistance, and guidance to CRSA staff.

AHCCCS also conducts an annual on-site Operational and Financial review that includes a review of subcontractor contracts, credentialing files, interviews with staff, and observations of selected operations. AHCCCS maintains a master review tool that incorporates all state and federal requirements. The Acute Care Contractor review tool was modified for use in conducting the CRSA OFR because CRSA is not an Acute Care Contractor. Not all items are reviewed each year. However, all are reviewed at least every three years. Special areas of interest identified by AHCCCS also may be included in the review as information only and are not included in the scoring of the review.

In addition, AHCCCS regularly obtains feedback from the Acute Care/ALTCS Contractors on CRSA issues. The Acute Care/ALTCS Contractors are likely to be the first to know if CRS recipients or providers are having difficulty navigating the CRS system, such as scheduling an appointment, and they report these problems to AHCCCS on an ongoing basis. The monthly meeting with plan medical directors provides a forum to keep this dialogue open. The CRSA medical director attends these meetings. In combination, these oversight activities provide AHCCCS with an accurate assessment of CRSA compliance with State and Federal requirements.

E. Assessment of Strengths and Weaknesses

At the time of this review, CRSA was performing under a Notice to Cure. The Notice to Cure identified major quality of care concerns that CRSA was required to immediately correct. The concerns identified in the Notice to Cure were reviewed during the Operational and Financial Review. This gave AHCCCS the opportunity to emphasize the

importance of these areas of concern and reinforce the need for improvement. The findings of the CYE 2005 Operational and Financial Review demonstrate that CRSA continues to have many opportunities for improvement. The greatest opportunities are in the area of recipient services and utilization management.

The major issues identified in recipient services are with the written materials provided to recipients, such as the recipient handbook and the new recipient orientation packet. CRSA failed to submit the recipient handbook to AHCCCS for review and approval as required by contract and CRSA is unable to document that it reviews and approves the materials distributed by its subcontractors. In addition, CRSA does not have a systematic way to track, trend, analyze and correct problems identified by member complaints/grievances.

In the area of recipient services, a full 75 percent of the standards reviewed were rated as noncompliant. Of these, 55 percent were identified as noncompliant in the CYE 2004 review and required a corrective action. The corrective action plan submitted by CRSA in October 2005 included actions to be taken by CRSA to bring these issues in compliance. This review identified minimal progress on implementing the activities identified in the corrective action plan.

In the area of Utilization Management, 73.7 percent of the standards reviewed were noncompliant. Another 15.8 percent were rated as only partially compliant. Together 89.3 percent of the utilization management standards reviewed in CYE 2005 require major improvement. Of significant concern is the lack of medical director oversight and involvement in the clinical review process. This was evident in almost all utilization management areas such as prior authorization and inpatient stay reviews. Consistency in the review process is not reviewed or documented by CRSA and the denial process is not properly documented. Insufficient information was included in this year's review to determine how many of these issues were identified in previous reviews. However, a review of the corrective action plan dated January, 26, 2005, indicated that many activities designed to resolve these issues were identified as completed. This would indicate that CRSA is not monitoring compliance with or following its own policies.

In the area of General Administration, almost 82 percent of the 44 standards reviewed were scored as partially compliant or noncompliant. The major issues identified here are that CRSA does not appear to be adequately staffed and that CRSA does not adequately review and monitor the activities delegated to its four regional clinics. In the 2005 review the business continuity plan, cultural competency, and corporate compliance were scored as part of General Administration. In the 2004 review these were scored separately. For comparative purposes, the findings of the 2005 review are identified and scored separately. This comparison indicates that CRSA has actually lost ground in compliance with business continuity and cultural competency. The reasons for this should be further explored and corrected.

In the Quality Management area, which was the impetus for the Notice to Cure, CRSA was either partially compliant or noncompliant in 64.7 percent of the standards reviewed.

The major issues were staffing, the lack of a peer review process, an inadequate process for oversight of delegated functions, and an inadequate system to collect, analyze and report on quality of care and/or grievance issues.

The area of greatest improvement from the previous review is in the delivery systems. CRSA is able to demonstrate improved communications with its network in the area of appointment standards and communication with the recipients' health plan. CRSA participates in a workgroup with AHCCCS health plans and regional clinics. This forum fosters improved communication among all parties and has proven very beneficial.

Comparison to the CYE 2004 Review

Comparisons to the CYE 2004 review are displayed in Table 4. Due to the significant differences in the 2004 and 2005 reviews, these comparisons must be reviewed with caution. The number of standards reviewed between the years is significantly different: 61 in CYE 2004 and 159 in CYE 2005. In some areas the number of standards reviewed in a year are too few to adequately represent that area. For example, in CYE 2004 only two Grievance standards were reviewed; this does not adequately reflect performance in the Grievance area. Despite the limitations, a comparison between CYE 2004 and CYE 2005 are further displayed in Figures 4.1 through 4.9.

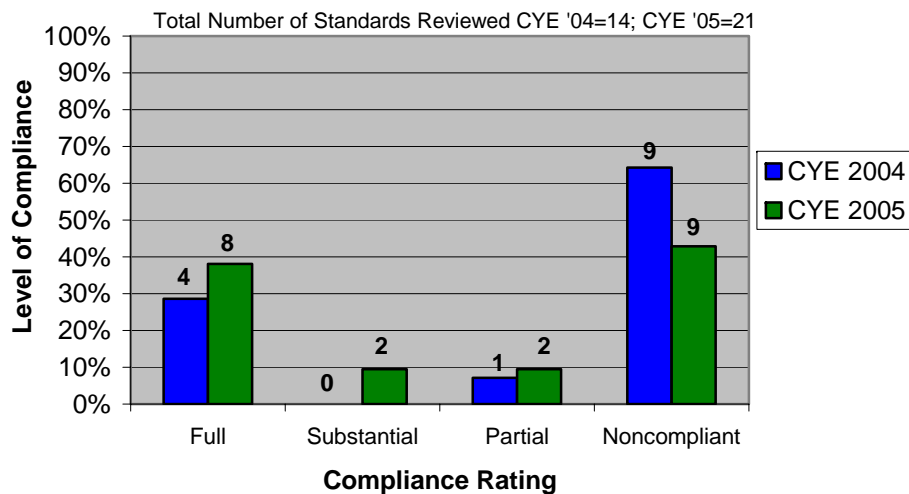
F. Conclusion

As is evident from the data, CRSA is in full compliance with only 29.6 percent of the standards reviewed in CYE 2005. This is somewhat surprising given the corrective action it was required to submit following its CYE 2004 review. The corrective action plan suggested a commitment to addressing identified deficiencies and implementing recommended changes. However, many of the actions identified by CRSA in its corrective action plan have yet to be implemented and the results of these actions were not evident at the time of this review. It appears that the Quality Management/Utilization Management Programs exists on paper only. Current staffing levels do not support the implementation of required quality management/utilization management activities. This has been an ongoing issue and must be addressed by CRSA before significant progress can be made.

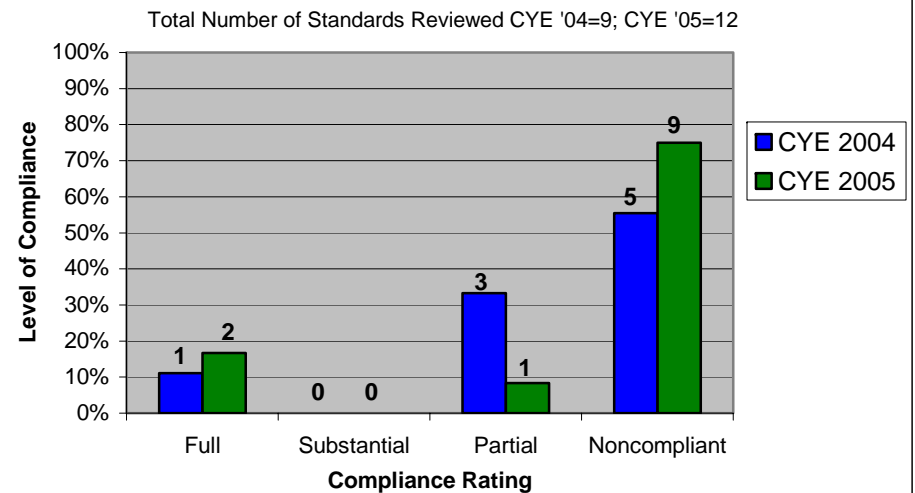
Table 4
Selected Comparison of CRS CYE 2004 to CYE 2005 OFR Findings

Program Areas	Number of Standards Reviewed		Compliance Rating for Standard							
			Full		Substantial		Partial		Noncompliant	
	CY 2004	CY 2005	CY 2004	CY 2005	CY 2004	CY 2005	CY 2004	CY 2005	CY 2004	CY 2005
Delivery System	14	21*	28.6%	38.1%	0.0%	9.5%	7.1%	9.5%	64.3%	42.9%
Recipient Services	9	12*	11.1%	16.7%	0.0%	0.0%	33.3%	8.3%	55.5%	75.0%
Grievance and Appeals	2	20	50.0%	45.0%	0.0%	45.0%	50.0%	0.0%	0.0%	10.0%
Utilization Management	10	19	20.0%	5.3%	0.0%	5.3%	10.0%	15.8%	70.0%	73.7%
Quality Management	4	17*	25.0%	29.4%	25.0%	5.9%	0.0%	29.4%	50.0%	35.3%
Cultural Competency	10	9	30.0%	0.0%	30.0%	0.0%	30.0%	55.5%	10.0%	44.4%
Business Continuity Plan	3	8	33.3%	0.0%	0.0%	0.0%	66.7%	12.5%	0.0%	87.5%
General Administration	9	14	33.3%	21.4%	0.0%	7.1%	22.2%	28.5%	44.4%	42.8%
Overall	61	159**	26.2%	29.6%	6.6%	9.4%	21.3%	16.4%	45.9%	44.7%
* excludes standards reviewed for "Information Only" and "Not Applicable"										
** excludes Corporate Compliance, Financial Management, Claims, and Encounters as these were not reviewed in CY 2004										

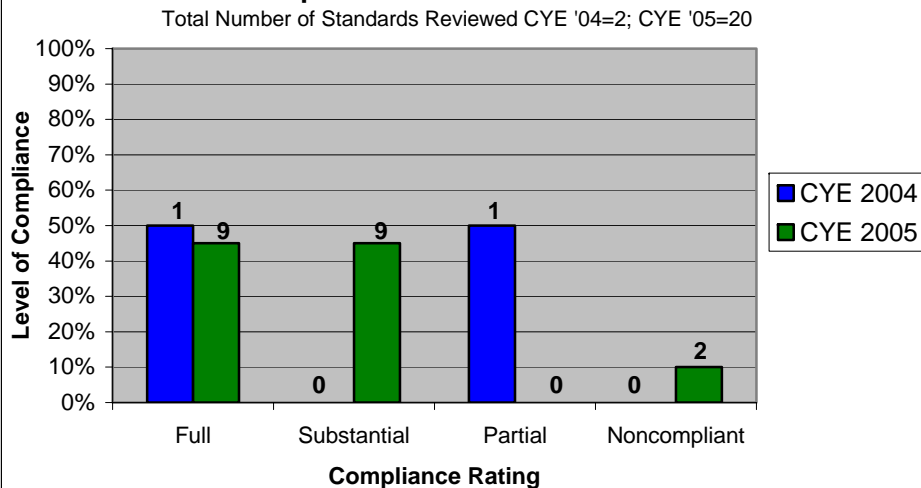
**Figure 4.1: Delivery System
Comparison of CYE 2004 to 2005**



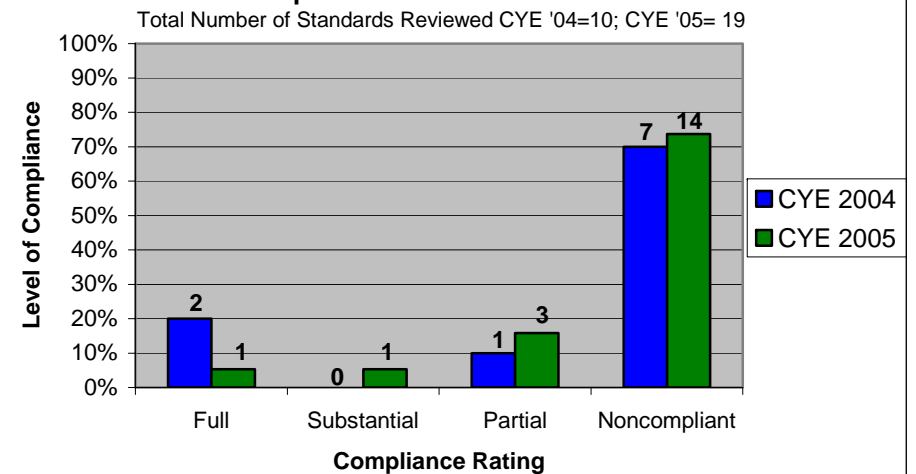
**Figure 4.2: Recipient Services
Comparison of CYE 2004 to 2005**



**Figure 4.3: Grievance and Appeals
Comparison of CYE 2004 to 2005**

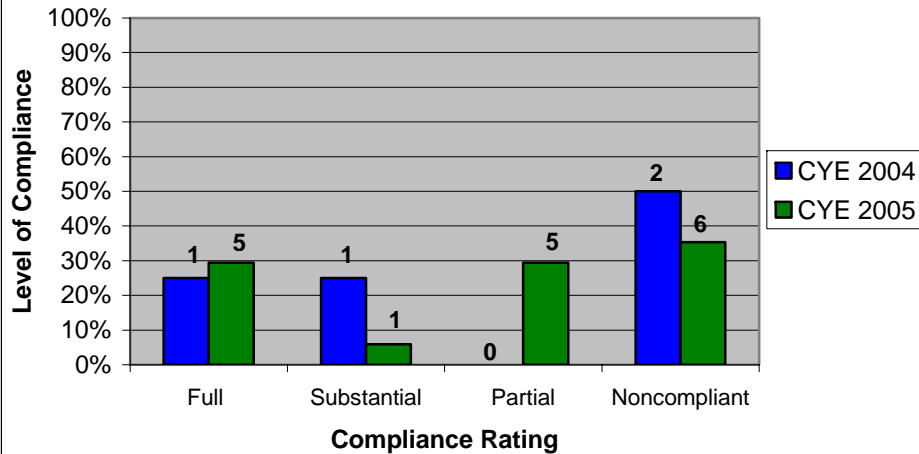


**Figure 4.4: Utilization Management
Comparison of CYE 2004 to 2005**



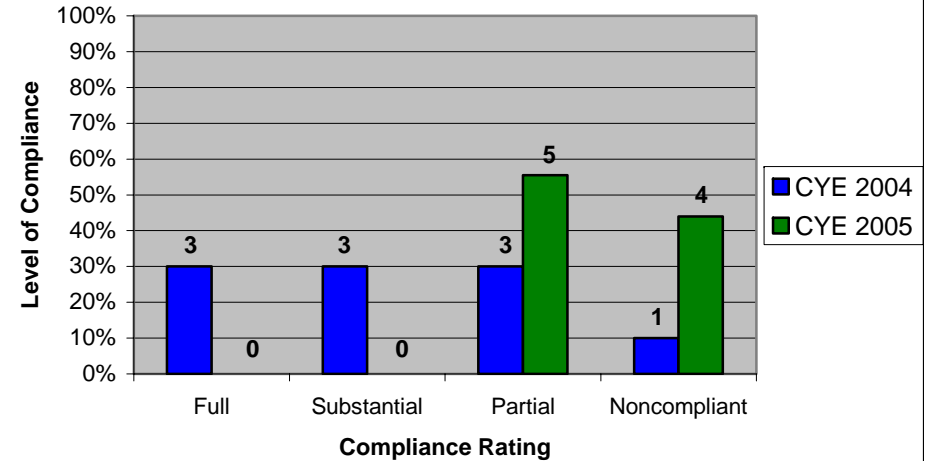
**Figure 4.5: Quality Management
Comparison of CYE 2004 to 2005**

Total Number of Standards Reviewed CYE '04=4; CYE '05=17



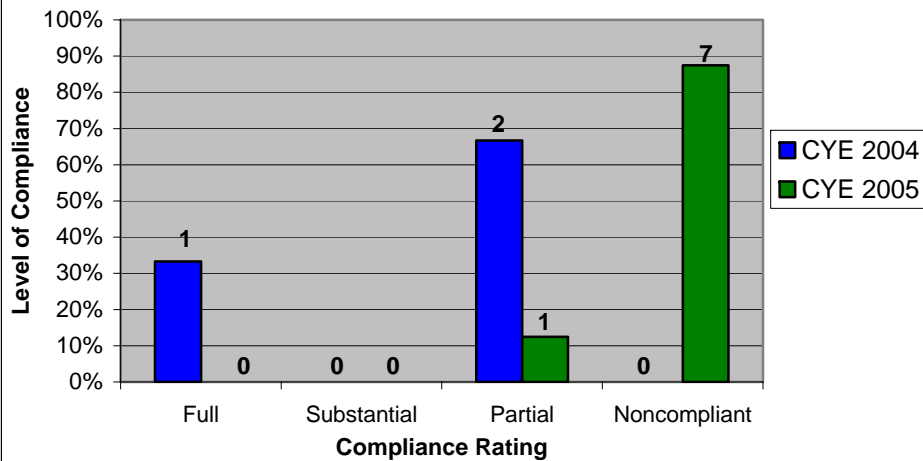
**Figure 4.6: Cultural Competency
Comparison of CYE 2004 to 2005**

Total Number of Standards Reviewed CYE '04=10; CYE '05=9



**Figure 4.7: Business Continuity Plan
Comparison of CYE 2004 to 2005**

Total Number of Standards Reviewed CYE '04=3; CYE '05=8



**Figure 4.8: General Administration
Comparison of CYE 2004 to 2005**

Total Number of Standards Reviewed CYE '04=9; CYE '05=14

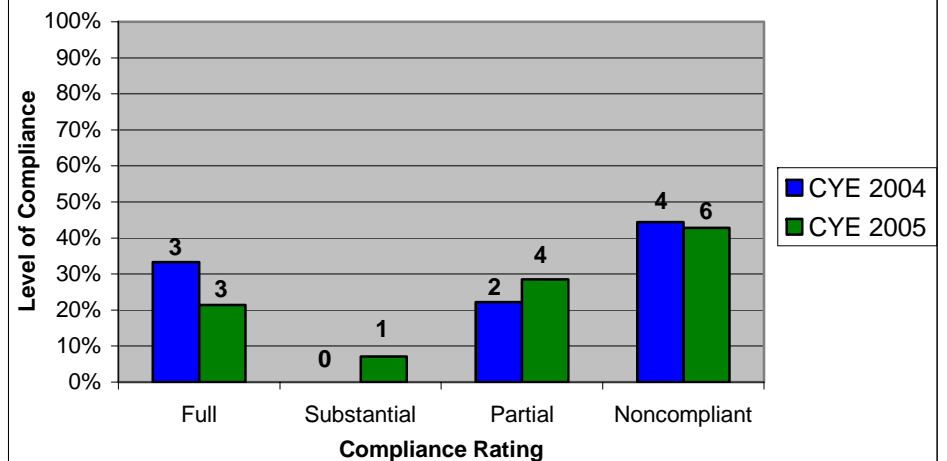
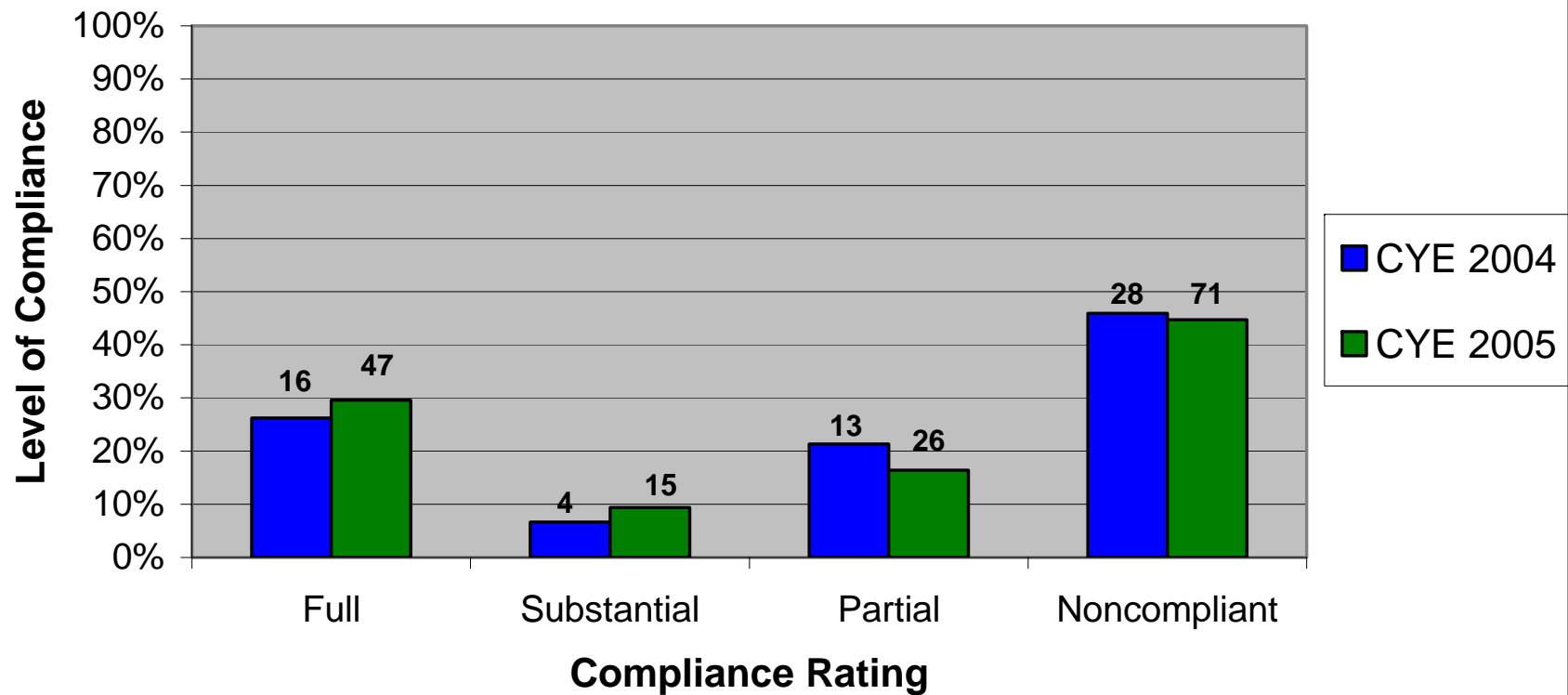


Figure 4.9: Comparison of Overall Findings CYE 2004 to 2005

Total Number of Standards Reviewed CYE '04=61; CYE '05=159



Notes

¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR 400, 430, et al., Final Protocol, Version 1.0, February 11, 2003, p. 1.

² State of Arizona Health Care Cost Containment System, Quality Assessment and Performance Improvement Strategy, October 2005, p. 3.

³ DHS, CMS Region IX, p. 8.

⁴ AHCCCS, CRSA OFR CYE 05 Operational and Financial Review, p. 4.

V. SUMMARY AND RECOMMENDATIONS

Summary

CRSA is a unique program that provides a limited scope of services to a special needs population of disabled or potentially disabled children. Due to the unique nature of this program, the usual standards used to evaluate quality of care and service such as HEDIS[®] measures are not relevant to CRSA. This presents some challenges to measuring and evaluating the quality of care/service delivered by the CRS program. AHCCCS has been working very closely with CRSA over several years to identify performance measures unique to CRSA and designed to measure quality of service. The parameters of these performance measures have been included in the July 1, 2005 contract renewal. Measurement and reporting will begin in contract year 2006.

Despite close monitoring, technical assistance, and oversight by AHCCCS, CRSA has not been successful in demonstrating the ability to select and implement performance improvement projects that effectively result in improving health status or outcomes, or have a positive impact on recipient satisfaction or their general growth and development. In contract year ending 2005, CRSA made no progress with its performance improvement projects. No projects were completed and no new performance improvement projects were implemented. To help improve the likelihood of success, AHCCCS has worked closely with CRSA over the past year to define the methodology for the performance improvement project “Improving Pediatric to Adult Transition Services for Youth,” and has included the methodology for this PIP into the CYE 2006 contract renewal. This should help CRSA implement and complete this performance improvement project.

The results of the CYE 2005 Operational and Financial review of CRSA were disappointing. Only 29.6% of the standards reviewed in CYE 2005 were rated at full compliance. These findings support the decision by AHCCCSA to issue a Notice to Cure. The corrective action plans submitted by CRSA in response to identified deficiencies are either not implemented or not documented. Lack of implementation and follow through appear to have become standard operating procedure at CRSA as many recommendations were repeated from previous years. AHCCCS now meets with CRSA on a regular basis to follow-up on corrective action plan activities. These meetings are well documented and should contribute to significant improvement in the coming year. If significant improvement is not evident at the next review, further sanctions should be considered. Repeated failure to perform should not be allowed.

Recommendations

CRSA should more clearly define the role of the quality management/quality improvement committee with careful attention to the role of the medical director. This recommendation has been made several times and was a factor in the Notice to Cure.

CRSA should exercise greater care in the identification, development, implementation and evaluation of performance improvement projects. No performance improvement projects have been completed to date.

CRSA should develop, implement and document a process for oversight of the Regional Contractors to ensure compliance with federal and state requirements. The oversight process used by AHCCCS is thorough, complete, and well documented. CRSA should use the AHCCCS program as a model.

CRSA should develop an internal monitoring process to ensure that corrective actions are implemented, documented, and sustained. On numerous occasions CRSA has submitted corrective action plans that meet compliance standards and then failed to implement them.

CRSA should re-evaluate its commitment to implement a Quality Management/Utilization Management Program. There was no documentation presented to support the existence or implementation of a comprehensive Quality Management/Utilization Management Program. Current staffing levels do not support the implementation of the required activities. This has been an ongoing issue that must be addressed by CRSA before significant progress can be made.

BIBLIOGRAPHY

Federal Documents

Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol, Version 1.0, February 11, 2003.

Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities. Final Protocol, Version 1.0, May 1, 2002.

Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities. Final Protocol, Version 1.0, May 1, 2002.

AHCCCS and CRS Documents

Arizona Health Care Cost Containment System (AHCCCS) agreement with Arizona Department of Health Services (ADHS) for Children's Rehabilitative Services (CRS). Contract /RFP No. YH00-0027. July 1, 2004 to June 30, 2005.

Arizona Health Care Cost Containment System (AHCCCS). CRSA Operational and Financial Review Contract Year Ending 2005. June 28 to June 30, 2005.

Children's Rehabilitative Services. CYE 2005 Quality Management Work Plan and CYE 2004 Quality Management Evaluation.

Children's Rehabilitative Services. CYE 2005 Utilization Management Plan and CYE 2004 Evaluation.

Arizona Health Care Cost Containment System (AHCCCS). "To Children's Rehabilitative Services (CRS)." 16 February 2005. Response to three performance improvement projects, Improving Pediatric to Adult Services for Youth (CYE 2005), Baseline Report Accuracy of WeeFIM Assessments (CYE 2004) and Cleft Lip/Cleft Palate (CYE 2003).

Arizona Health Care Cost Containment System (AHCCCS). “To Children’s Rehabilitative Services (CRS).” 22 April 2005. Response to CYE 2005 Quality Management/Utilization Management Plan, CYE 2004 Quality Management/Utilization Management Evaluation, PIP Proposal Improving Pediatric to Adult Transition Services for Youth (CYE 2005) and PIP Baseline Report Accuracy of WeeFIM Assessments (CYE 2004).

Arizona Health Care Cost Containment System (AHCCCS). “To Children’s Rehabilitative Services (CRS).” 3 June 2005. Response to CRS plan to discontinue the WeeFIM performance improvement project.

Arizona Health Care Cost Containment System (AHCCCS). “To Children’s Rehabilitative Services (CRS).” 9 August 2005. Response to request to replace WeeFIMS tool with a different tool to assess functional status in children with Spina Bifida and Cerebral Palsy.

Arizona Health Care Cost Containment System (AHCCCS). “To Children’s Rehabilitative Services (CRS).” 9 July 2004. Approval of PIP Proposal Increased Accuracy of WeeFIM Assessments and Rejection of the Interim Report on Improving Cleft Lip/Cleft Palate Follow-up Visits.

Arizona Health Care Cost Containment System (AHCCCS). “To Children’s Rehabilitative Services (CRS).” 20 July 2004. Approval of the Revised PIP Proposal on Improving Cleft Lip/Cleft Palate Follow-up Visits.

Arizona Health Care Cost Containment System (AHCCCS). “To Children’s Rehabilitative Services (CRS).” Response to CYE 2004 Quality Management /Utilization Management Plan, CYE 2003 Quality Management/Utilization Management Evaluation, PIP Proposal Increase Accuracy of WeeFIM Assessments and the PIP Interim Report Improving Cleft Lip/Cleft Palate Follow-up Visits.

Arizona Department of Health Services, Children’s Rehabilitative Services. (AHCCCS). “To AHCCCS.” 18 October 2004. Submission of WeeFIM final report and expectation that the project is completed.

Children's Rehabilitative Services. CYE 2003 Quality Improvement Project Methodology, Increase Accuracy of WeeFIM Assessments.

Children's Rehabilitative Services. CYE 2004 Quality Management Work Plan and CYE 2004 Quality Management Evaluation.

Children's Rehabilitative Services. CYE 2004 Utilization Management Plan and CYE 2003 Evaluation.

Children's Rehabilitative Services. FY 2003 Performance Improvement Project Methodology, Increase Appropriate Cleft Lip/Cleft Palate Follow-up Visits.

Children's Rehabilitative Services. Performance Improvement Project Methodology. December 2004, Improving Pediatric to Adult Transition Services for Youth.